		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018143

Facility Name: Fair Havens Christian Home

Address: 1790 South Fairview Avenue (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: 217-429-2551 **Fax #** ( )

IDPA ID Number: 23-7437316001

Date of Initial License for Current Owners: 1975

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501©3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2001 to June 30, 2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	161	Skilled (SNF)	161	58,765	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	161	TOTALS	161	58,765	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,322	14,313	2,464	39,099	8
9	SNF/PED					9
10	ICF	6,129	9,387		15,516	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,451	23,700	2,464	54,615	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.94%

D. How many bed-hold days during this year were paid by Public Aid?
299 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/12/1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified 15 and days of care provided 3,837

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fair Havens Christian Home # 0018143 **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	235,701	30,370	13,054	279,125		279,125		279,125			1
2	Food Purchase		292,396		292,396		292,396	(2,354)	290,042			2
3	Housekeeping	166,965	33,099		200,064		200,064		200,064			3
4	Laundry	100,292	20,640		120,932		120,932		120,932			4
5	Heat and Other Utilities			143,878	143,878		143,878	(7,035)	136,843			5
6	Maintenance	60,119	27,557	43,975	131,651		131,651	7,180	138,831			6
7	Other (specify):*											7
8	**TOTAL General Services**	563,077	404,062	200,907	1,168,046		1,168,046	(2,209)	1,165,837			8
	B. Health Care and Programs											
9	Medical Director			11,560	11,560		11,560		11,560			9
10	Nursing and Medical Records	2,070,207	110,807	4,155	2,185,169		2,185,169		2,185,169			10
10a	Therapy			134,223	134,223		134,223		134,223			10a
11	Activities	30,567		8,763	39,330		39,330		39,330			11
12	Social Services	119,303	5,756		125,059		125,059		125,059			12
13	Nurse Aide Training											13
14	Program Transportation		1,410		1,410		1,410		1,410			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,220,077	117,973	158,701	2,496,751		2,496,751		2,496,751			16
	C. General Administration											
17	Administrative	108,757	2,387	232,200	343,344		343,344	(137,871)	205,473			17
18	Directors Fees											18
19	Professional Services			8,678	8,678		8,678	13,460	22,138			19
20	Dues, Fees, Subscriptions & Promotions			26,415	26,415		26,415	(5,980)	20,435			20
21	Clerical & General Office Expenses	80,898	8,698	30,693	120,289		120,289	65,152	185,441			21
22	Employee Benefits & Payroll Taxes			498,083	498,083		498,083	21,904	519,987			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,283	9,283		9,283	6,249	15,532			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,207	79,207		79,207	2,614	81,821			26
27	Other (specify):*											27
28	**TOTAL General Administration**	189,655	11,085	884,559	1,085,299		1,085,299	(34,472)	1,050,827			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,972,809	533,120	1,244,167	4,750,096		4,750,096	(36,681)	4,713,415			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fair Havens Christian Home #0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			223,723	223,723	(17,400)	206,323	31,482	237,805			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,423	42,423		42,423	(8,172)	34,251			32
33	Real Estate Taxes			187	187		187		187			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			266,333	266,333	(17,400)	248,933	23,310	272,243			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			7,573	7,573		7,573		7,573			39
40	Barber and Beauty Shops	21,061	867	406	22,334		22,334		22,334			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,148	88,148		88,148		88,148			42
43	Other (specify):* Apt/Cong			399,583	399,583	17,400	416,983	(15,742)	401,241			43
44	**TOTAL Special Cost Centers**	21,061	867	495,710	517,638	17,400	535,038	(15,742)	519,296			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,993,870	533,987	2,006,210	5,534,067		5,534,067	(29,113)	5,504,954			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,354)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,294)	5		5
6	Rented Facility Space	(3,000)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22,843	30		9
10	Interest and Other Investment Income	(25,756)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,909)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(15,742)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	4,000	21		24
25	Fund Raising, Advertising and Promotional	(5,980)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	51,058			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 13,866		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(42,979)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (42,979)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (29,113)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Fair Havens Christian Home

ID# 0018143

Report Period Beginning: July 1, 2001

Ending: June 30, 2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine Loss	$ 3,690	17	1
2	Net Activity (income) expense	15	17	2
3	Equipment Disposal Loss	30,226	17	3
4	Guest Meals Income	(425)	17	4
5	Increase in Cash Value Life	(32)	17	5
6	PY Deferred Bond Costs Expense	17,584	32	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	51,058		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,354)	0	0	0	0	0	0	0	0	0	0	(2,354)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(11,294)	4,259	0	0	0	0	0	0	0	0	0	(7,035)	5
6	Maintenance	0	7,180	0	0	0	0	0	0	0	0	0	7,180	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,648)	11,439	0	0	0	0	0	0	0	0	0	(2,209)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	33,474	(171,345)	0	0	0	0	0	0	0	0	0	(137,871)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,460	0	0	0	0	0	0	0	0	0	13,460	19
20	Fees, Subscriptions & Promotions	(5,980)	0	0	0	0	0	0	0	0	0	0	(5,980)	20
21	Clerical & General Office Expenses	1,091	64,061	0	0	0	0	0	0	0	0	0	65,152	21
22	Employee Benefits & Payroll Taxes	0	21,904	0	0	0	0	0	0	0	0	0	21,904	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,249	0	0	0	0	0	0	0	0	0	6,249	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,614	0	0	0	0	0	0	0	0	0	2,614	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	28,585	(63,057)	0	0	0	0	0	0	0	0	0	(34,472)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	14,937	(51,618)	0	0	0	0	0	0	0	0	0	(36,681)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Havens Christian Home # 0018143 **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	22,843	8,639	0	0	0	0	0	0	0	0	0	31,482	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,172)	0	0	0	0	0	0	0	0	0	0	(8,172)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	14,671	8,639	0	0	0	0	0	0	0	0	0	23,310	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(15,742)	0	0	0	0	0	0	0	0	0	0	(15,742)	43
44	**TOTAL Special Cost Centers**	(15,742)	0	0	0	0	0	0	0	0	0	0	(15,742)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	13,866	(42,979)	0	0	0	0	0	0	0	0	0	(29,113)	45

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes, Inc.	100.00%	$ 4,259	$ 4,259	1
2	V	6	Maintenance				7,180	7,180	2
3	V	17	Administrative	232,200			60,855	(171,345)	3
4	V	18	Directors						4
5	V	19	Professional Services				13,460	13,460	5
6	V	20	Fees, Subscriptions						6
7	V	21	Clerical				64,061	64,061	7
8	V	22	Employee Benefits				21,904	21,904	8
9	V	23	Inservice Training						9
10	V	24	Travel & Seminar				6,249	6,249	10
11	V	26	Insurance				2,614	2,614	11
12	V	30	Depreciation				8,639	8,639	12
13	V								13
14	Total			$ 232,200			$ 189,221	$ * (42,979)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: ne 30, 2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1993-A General Rev Bond	x		Debt Restructure	$3,110.63	01/01/93	$ 420,000	$ 353,220	01/01/18	0.0750	$ 26,681	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Construction note	x		Nursing Home - paid off		08/01/01				0.0850	15,742	6
7												7
8												8
9	TOTAL Facility Related				$3,110.63		$ 420,000	$ 353,220			$ 42,423	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 420,000	$ 353,220			$ 42,423	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Havens Christian Home COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0018143

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-21-428-011	21-16-2 Mueller's 3rd RSVY	$ 298.08	$
2.	07-07-15-451-006	Hickory Point Christian Vill. Lot 1	$ 2,604.88	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 2,902.96	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,500 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	57,000	1972	$ 54,638	1
2	Home Office			8,353	2
3	TOTALS	57,000		$ 62,991	3

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1977	1977	$ 2,180,767	$ 51,312	40	$ 54,520	$ 3,208	$ 1,351,618	4
5					384,841		20	19,242	19,242		5
6	6		1983	1983	109,815	2,745	35	3,138	393	50,783	6
7											7
8	Home Office Allocation				59,729	1,750		1,750		29,380	8
	Improvement Type**										
9	Wall Guards			1979	485		15			485	9
10	Garage			1979	4,167	139	30	139		3,266	10
11	Heat Tapes			1980	2,151		15			2,151	11
12	Heating System			1981	14,100		10			14,100	12
13	Wall Coverings			1981	1,277		10			1,277	13
14	Heating Control System			1982	20,503	772	20	772		20,503	14
15	Fence Guard Rail			1982	2,027		10			2,027	15
16	Electric Work			1982	2,133		10			2,133	16
17	Fire Alarm			1982	858	43	20	43		846	17
18	New Office			1983	2,700	90	30	90		1,755	18
19	Wallcovering			1983	2,301		10			2,301	19
20	Tiling			1983	615		10			615	20
21	Office Remodel			1984	2,594	86	30	86		1,584	21
22	Window Installation			1984	2,083		10			2,083	22
23	Down Spouts			1984	639		10			639	23
24	Floor Covering			1984	550		10			550	24
25	Roof Work			1984	163,201	4,080	40	4,080		78,963	25
26	Electric Door			1984	10,229		10			10,229	26
27	Floor Covering			1985	3,457		10			3,457	27
28	Fire Alarm			1985	1,705	85	20	85		1,481	28
29	Windows			1985	3,558		10			3,558	29
30											30
31	Roof			1985	29,843		15			29,843	31
32	Door Kick Guards			1985	419		10			419	32
33	Electrical Recepticals			1986	2,419	121	20	121		1,956	33
34	Wiring			1987	7,530	376	20	376		5,795	34
35	Ceiling			1987	300		10			300	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Rewiring	1987	$ 1,600	$ 80	20	$ 80	$	$ 1,173	37
38	Wallpapering	1989	505		5			505	38
39	Signs	1989	1,224		5			1,224	39
40	Soap Dispensers	1989	672		5			672	40
41	Compressor Freezer	1989	810		5			810	41
42	Storage Cabinet	1990	1,100	73	15	73		906	42
43	Tempering Valve	1990	3,199	213	15	213		2,627	43
44	Remodel Dining Room	1991	4,708	235	20	235		2,820	44
45	Install Panic Bars	1991	780		10			780	45
46	Install Window	1991	988	66	15	66		743	46
47	Flooring	1991	4,380		5			4,380	47
48	Roof Repair	1991	29,860	1,991	15	1,991		22,233	48
49	A/C Compressor	1991	1,076		5			1,076	49
50	Touchpads Exit Door	1991	792	15	10	15		792	50
51	Stainless Steel Sink	1991	1,630	41	10	41		1,630	51
52	Walkway Canopy	1991	4,412	221	20	221		2,376	52
53	Showers	1991	3,669	152	10	152		3,669	53
54	Remodel Office	1992	8,715	436	20	436		4,396	54
55	Door Locks & Magnets	1992	2,540	254	10	254		2,498	55
56	Interior Landscaping	1992	3,839	384	10	384		3,680	56
57	Handrails	1993	12,800	853	15	853		8,104	57
58	Wall Cabinets	1993	2,564	171	15	171		1,596	58
59	Bathroom Remodel	1993	12,341	617	20	617		5,656	59
60	Nurses Station Desks	1994	18,588	929	20	929		7,819	60
61	Alarm/Auto Door	1994	4,257	426	10	426		3,514	61
62	Cabinets	1994	1,480	99	15	99		800	62
63	Carpeting in Office	1993	979		5			979	63
64	Gas Rooftop Piping	1994	4,905	245	20	245		1,899	64
65	Heating & A/C Unit	1994	5,565	278	20	278		2,155	65
66	Remodel Garage	1995	3,704	370	10	370		2,744	66
67	Remodel Nurses Station	1995	15,656	1,566	10	1,566		11,223	67
68	Thru Wall A/C Unit	1995	3,120	390	8	390		2,795	68
69	Flourescent Light Covers	1995	1,218		5			1,218	69
70	TOTAL (lines 4 thru 69)		$ 3,180,672	$ 71,704		$ 94,547	$ 22,843	$ 1,733,589	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,180,672	$ 71,704		$ 94,547	$ 22,843	$ 1,733,589	1
2	Roof Work	1995	52,000	3,467	15	3,467		24,558	2
3	Service Sink	1995	1,003	100	10	100		717	3
4	Wallcovering Dayroom Station 1	1995	2,573		5			2,573	4
5	Baseboard Pipe	1995	2,978		5			2,978	5
6	Thru Wall A/C	1995	3,120	390	8	390		2,665	6
7	Shower Valves	1995	1,807	181	10	181		1,222	7
8	Resident Room Signs	1995	1,516		5			1,516	8
9	Utility Room Cabinet	1995	599	40	15	40		270	9
10	Magnets for Fire Doors	1995	795		5			795	10
11	Fire Door Closers	1995	1,200		5			1,200	11
12	Install 2 Deck Faucets	1995	826		5			826	12
13	Nurse Call System	1995	925	93	10	93		620	13
14	Install Sprinkler Laundry	1995	557	56	10	56		373	14
15	Electronic Thermostats	1995	733		5			733	15
16	Breakers 6/receptacles	1995	883		5			883	16
17	Remodel Main Lobby	1995	4,569		5			4,569	17
18	Remodel Station	1996	12,472		5			12,472	18
19	Rooftop Heating/AC Dining Room	1996	11,975	1,198	10	1,198		7,787	19
20	Floorwork Dayroom	1996	2,247		5			2,247	20
21	Heating & A/C Station	1996	7,550	755	10	755		4,845	21
22	Floorwork Dining Room	1996	6,974	697	10	697		4,472	22
23	Water Softener	1996	10,580	1,058	10	1,058		6,524	23
24	Water Heaters	1996	39,422	3,942	10	3,942		24,309	24
25	2 Sprinkler Cooler	1996	772	53	5	53		772	25
26	Remodel Station	1996	8,261	689	5	689		8,261	26
27	Shelving Linen Closet	1997	540	81	5	81		540	27
28	Gas Piping in Laundry	1997	1,155	116	10	116		609	28
29	Heating & A/C Rooftop	1997	8,950	895	10	895		4,624	29
30	Floorwork Station 4 Hall	1997	10,153	1,015	10	1,015		5,160	30
31	Dining Room Announcement	1997	549	100	5	100		549	31
32	Remodel Beauty Shop	1997	1,370	122	5	122		1,370	32
33	Energy Management System	1997	14,637	732	20	732		3,416	33
34	TOTAL (lines 1 thru 33)		$ 3,394,363	$ 87,484		$ 110,327	$ 22,843	$ 1,868,044	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,394,363	$ 87,484		$ 110,327	$ 22,843	$ 1,868,044	1
2	Remove Slab Freezer Area	1997	2,860		3			2,860	2
3	Floor Tile - Station 4 Rooms	1998	7,500	1,500	5	1,500		6,500	3
4	Station 3 Carrier FR A/C	1998	7,597	760	10	760		3,103	4
5	Carpet Chapel/Lobby/Office	1998	2,483	497	5	497		2,027	5
6	Wood Cove BS/60 Rooms	1998	9,412	1,882	5	1,882		7,685	6
7	Alarm System	1998	11,937	1,194	10	1,194		4,870	7
8	Wallpaper Station 1 & 2 Rooms	1998	38,443	7,689	5	7,689		31,370	8
9	Ventilation - Electric Room	1999	1,875	375	5	375		1,406	9
10	48-Safety Grab Bars	1999	864	173	5	173		634	10
11	161-Glass/Resident Walls	1999	2,256	226	10	226		829	11
12	Install Grab Bars	1999	2,401	240	10	240		840	12
13	Install 24V Door Closer	1999	1,189	238	5	238		833	13
14	Water Heater - Station 3	1999	655	131	5	131		426	14
15	Remodel Station 4	1999	26,585	1,772	15	1,772		5,751	15
16	Back Door Alarm Pad	1999	2,874	287	10	287		933	16
17	Nurse Call Units	1999	598	60	10	60		190	17
18	Front Countertop	1999	881	59	15	59		187	18
19	Mixing Valve/Install	1999	524	105	5	105		324	19
20	Pella Storm Window - 13	1999	527	105	5	105		324	20
21	Smoke Detectors-4	1999	553	55	10	55		170	21
22	Carrier Rooftop Unit	1999	6,779	678	10	678		2,090	22
23	Wallpaper Station 3 Rooms	1999	23,706	4,741	5	4,741		14,607	23
24	Compressors (3)	2000	2,239	746	3	746		2,176	24
25	Cove Base-Station 3	2000	1,408	282	5	282		799	25
26	Baseboard	2000	1,371	274	5	274		754	26
27	Light Fixtures (2 Day Room)	2000	947	95	10	95		261	27
28	Floor Tile-Hall/Bath/Kitchen	2000	3,079	616	5	616		1,643	28
29	Panic	2000	1,059	212	5	212		512	29
30	Security Locks-Front Door	2000	900	180	5	180		405	30
31	Exhaust Fans (6)	2000	702	140	5	140		315	31
32	Carrier Rooftop Unit	2000	7,637	764	10	764		1,655	32
33	Ceiling Grid Covers	2000	1,418	177	8	177		369	33
34	TOTAL (lines 1 thru 33)		$ 3,567,622	$ 113,737		$ 136,580	$ 22,843	$ 1,964,892	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,567,622	$ 113,737		$ 136,580	$ 22,843	$ 1,964,892	1
2	Compressor Room 101	2000	1,131	75	15	75		156	2
3	REMODELING FHCH	2000	6,395	640	10	640		1,227	3
4	REMODELING PROJECT	2000	7,075	708	10	708		1,121	4
5	(2) BOILERS INSTALLED W/ EMERG LIGHTS	2001	20,942	2,094	10	2,094		2,269	5
6	Roof Top A/C Unit	7/2/2001	1,295	130	10	130		130	6
7	(2) BOILERS INSTALLED W/ EMERG LIGHTS	7/15/2001	782	78	10	78		78	7
8	Compressor - Dining Room A/C	10/6/2001	646	161	3	161		161	8
9	Replace (8) Fire Alarm-A/C Relays	4/17/2002	1,519	127	3	127		127	9
10	Heating & Cooling System - Office	6/14/2002	2,275	19	10	19		19	10
11	Locks (3) for Fire Doors	6/15/2002	4,077	34	10	34		34	11
12	Less: Disposals - 2 Water Heaters	6/1/2002	(39,422)					(24,309)	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,574,337	$ 117,803		$ 140,646	$ 22,843	$ 1,945,905	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 582,727	$ 87,875	$ 87,875	$	Various	$ 326,946	71
72	Current Year Purchases	42,237	2,395	2,395		Various	2,395	72
73	Fully Depreciated Assets	430,725				Various	430,725	73
74	Home Office Allocation	90,825	3,934	3,934			49,351	74
75	TOTALS	$ 1,146,514	$ 94,204	$ 94,204	$		$ 809,417	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1986 wayne Bus	1987	$ 30,743	$	$	$	8	$ 30,743	76
77	Patient Transportation	Van	1988	3,317				3	3,317	77
78	Home Office			10,701	2,955	2,955			7,481	78
79										79
80	TOTALS			$ 44,761	$ 2,955	$ 2,955	$		$ 41,541	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,828,603	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 214,962	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 237,805	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 22,843	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,796,863	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 414,454	$	$	86
87	Duplex/Equipment	6,753,027	217,795	1,140,736	87
88	Forysth Land Dev. & Assist Living	316,714			88
89	Other Equip/Bldgs	12,989	345	4,325	89
90	Land/Improvements	749,787	44,808	290,237	90
91	TOTALS	$ 8,246,971	$ 262,948	$ 1,435,298	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This Workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This Page	hrs							2
3	Licensed Recreational Therapist	is not	hrs							3
4	Licensed Physical Therapist	Applicable	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 671,789	$	1
2	Cash-Patient Deposits	18,365		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 18,913)	726,430		3
4	Supply Inventory (priced at FIFO)	35,929		4
5	Short-Term Investments	144,616		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Rec	7,065		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,604,194	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,453		13
14	Buildings, at Historical Cost	9,982,863		14
15	Leasehold Improvements, at Historical Cost	749,785		15
16	Equipment, at Historical Cost	1,387,502		16
17	Accumulated Depreciation (book methods)	(4,145,949)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	849,420		21
22	Other Long-Term Assets (spe CIP	316,714		22
23	Other(specify): Other Assets	5,066		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,559,854	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,164,048	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 92,922	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,365		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,080		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,578		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Apt Income	1,095,074		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,458,019	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	353,220		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Apt/Congregate Life Right	3,726,519		43
44	Security Deposit	1,115		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,080,854	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,538,873	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,625,175	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,164,048	$	48

***(See instructions.)**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,513,063	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,513,063	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	784,656	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **PY Deferred Bond Costs Expense**	(17,548)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 767,108	17
	B. Transfers (Itemize):		
18	**Transfer Out to Affiliate**	(654,996)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (654,996)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,625,175	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,366,197	1
2	Discounts and Allowances for all Levels	(807,304)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,558,893	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	190,448	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 190,448	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	26,282	13
14	Non-Patient Meals	2,779	14
15	Telephone, Television and Radio	1,050	15
16	Rental of Facility Space	3,000	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,573	19
20	Radiology and X-Ray	9,182	20
21	Other Medical Services	1,327	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 46,193	23
	D. Non-Operating Revenue		
24	Contributions	23,071	24
25	Interest and Other Investment Income***	69,387	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 92,458	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Sale of Equipment/Investments	(27,256)	28
28a	Residential/Congregate	457,987	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 430,731	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,318,723	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,168,046	31
32	Health Care	2,496,751	32
33	General Administration	1,085,299	33
	B. Capital Expense		
34	Ownership	266,333	34
	C. Ancillary Expense		
35	Special Cost Centers	429,490	35
36	Provider Participation Fee	88,148	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,534,067	40
41	**Income before Income Taxes (line 30 minus line 40)****	784,656	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 784,656	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,694	1,811	$ 42,709	$ 23.58	1
2	Assistant Director of Nursing	1,693	1,810	41,950	23.18	2
3	Registered Nurses	10,512	11,338	293,613	25.90	3
4	Licensed Practical Nurses	25,515	27,614	394,930	14.30	4
5	Nurse Aides & Orderlies	116,416	124,398	1,257,024	10.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,863	4,110	39,981	9.73	8
9	Activity Director	2,532	2,707	30,567	11.29	9
10	Activity Assistants					10
11	Social Service Workers	9,566	10,267	119,303	11.62	11
12	Dietician					12
13	Food Service Supervisor	1,663	1,849	19,794	10.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,271	25,413	215,907	8.50	15
16	Dishwashers					16
17	Maintenance Workers	5,838	6,527	60,119	9.21	17
18	Housekeepers	15,376	18,236	166,965	9.16	18
19	Laundry	9,265	10,433	100,292	9.61	19
20	Administrator	3,490	3,764	108,757	28.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,762	1,860	34,052	18.31	23
24	Clerical	3,814	3,948	46,846	11.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,974	2,072	21,061	10.16	33
34	TOTAL (lines 1 - 33)	238,244	258,157	$ 2,993,870 *	$ 11.60	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	304	$ 13,054	1.3	35
36	Medical Director	181	10,000	9.3	36
37	Medical Records Consultant	360	1,560	9.6	37
38	Nurse Consultant				38
39	Pharmacist Consultant	288	1,208	10.3	39
40	Physical Therapy Consultant	1,741	82,115	10a.3	40
41	Occupational Therapy Consultant	1,142	48,299	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	42	2,390	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	111	8,452	11.3	45
46	Other(specify) Dental	11	550	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,180	$ 167,628		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Blair Wagner	Administrator	0	$ 108,757
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,757

B. Administrative - Other

Description	Amount
Management Fee	$ 232,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 232,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand	Legal	$ 8,678
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,678

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 104,012
Unemployment Compensation Insurance	8,928
FICA Taxes	221,788
Employee Health Insurance	140,350
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	16,320
Employee Physicals	1,051
Employee Uniforms	5,634
Home Office Allocation	21,904
TOTAL (agree to Schedule V, line 22, col.8)	$ 519,987

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,060
Health Care Worker Background Check	
(Indicate # of checks performed)	
Software Support & Fees	5,719
Life Services Dues	7,009
Internet & Remote Fees	232
Subscriptions	1,513
Miscellaneous Dues & Fees	2,702
Licenses & Renewals	200
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,435

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 44
In-State Travel	4,096
Seminar Expense	3,216
Other	1,927
Home Office Allocation	6,249
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,532

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2001 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $7,009**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,001** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **88,148**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,354**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **To be supplied when completed.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Summary of Employee Benefits
Fair Haven Christian Homes

kdb
10/23/02

Payroll Taxes	Unemploy Contrib	Worker's Comp	Health Ins	Benefit Percentage	Employee Expense	Employee Uniforms	Employee Physicals	Employee Bonus	
154,278.61	5,528.00	70,292.00	97,650.00	84,563.50					
17,164.30	888.00	10,368.00	15,050.00	6,231.49					
15,625.92	552.00	6,420.00	7,700.00	6,672.63					
4,575.98	372.00	4,356.00	0.00	3,493.32					622,717.64
4,825.43	192.00	2,040.00	0.00	4,319.59					
10,158.65	953.00	5,736.00	7,350.00	5,882.49					
13,588.96	336.00	3,948.00	12,600.00		16,319.92	1,051.10	5,634.00	12,550.99	
1,568.78	107.00	852.00		921.98					
221,786.63	8,928.00	104,012.00	140,350.00	112,085.00	16,319.92	1,051.10	5,634.00	12,550.99	622,717.64

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Less: Employee Benefits